

Local Coverage Determination (LCD) for Treatment of Obstructive **SLEEP APNEA** (L28307)

Contractor Information

Contractor Name

Palmetto GBA

Contractor Number

01102

Contractor Type

MAC - Part B

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LCD Information

Document Information**LCD ID Number**

L28307

Primary Geographic Jurisdiction

California - Northern

LCD TitleTreatment of Obstructive **SLEEP APNEA****Oversight Region**

Region X

Contractor's Determination Number

J1B-08-0079-L

Original Determination Effective Date

For services performed on or after 09/02/2008

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Original Determination Ending Date**Revision Effective Date**

For services performed on or after 01/27/2011

Revision Ending Date**CMS National Coverage Policy**

Title XVIII of the Social Security Act, §1862(a)(1)(A) allows coverage and payment for only those services that are considered to be medically reasonable and necessary.

Title XVIII of the Social Security Act, §1833(e) prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

CMS Manual System, Pub. 100-03, *Medicare National Coverage Determinations Manual*, Chapter 1, Part 4, §240.4.

CMS Manual System, Pub. 100-02, *Medicare Benefit Policy Manual*, Chapter 16, §140. Dental Services Exclusion.

CMS Manual System, Pub. 100-01, *Medicare General Information, Eligibility and Entitlement Manual*, Chapter 5, §§70 and 70.1.

CMS Manual System, Pub. 100-02, *Medicare Benefit Policy Manual*, Chapter 15, §30.3.

CMS Manual System, Pub. 100-03, *Medicare National Coverage Determinations Manual*, Chapter 1, Part 4, §260.6. Specific services that may be covered when furnished by a dentist. If an otherwise noncovered procedure or service is performed by a dentist as incident to and as an integral part of a covered procedure or service performed by him/her, the total service performed by the dentist on such an occasion is covered.

CMS Manual System, Pub. 100-03, *Medicare National Coverage Determinations*, Chapter 1, Part 4, §240.4.1, CPAP Therapy for OSA.

Indications and Limitations of Coverage and/or Medical Necessity

Sleep Disordered Breathing, often referred to as Obstructive Sleep Apnea (OSA), is characterized by frequent episodes of hypopnea or apnea during sleep. Multiple detrimental physiologic changes may result from these hypopneic and apneic episodes. A monitored polysomnogram (or in some cases, selected home sleep studies) is necessary for correct diagnosis. Non-surgical and surgical approaches to obstructive apnea and hypopnea have been developed.

Intraoral orthotics, designed to keep the tongue and jaw forward, are effective in up to 80% of patients.

Continuous Positive Airway Pressure (CPAP):

Nasal CPAP prevents upper airway occlusion by splinting the pharyngeal airway with a positive pressure delivered through a nose mask. Used full time during sleep, it may be the most successful long-term approach to treatment, though this clearly creates practical problems for the patient.

With attention and compassionate follow-up, a large proportion of OSA patients will respond to CPAP and this more conservative approach must be aggressively pursued to the extent possible and feasible. Comprehensive surgical treatment may be effective in a portion of OSA patients, including those who fail nonsurgical treatment. Published data support site-directed treatment. To meet Medicare medical necessity guidelines, the record must clearly establish the inability to adequately address the patient's sleep apnea with a more conservative approach and the necessary, expected improvement attainable by each component of any proposed surgery with specific, objective evidence of the site(s) of obstruction.

Uvulopalatopharyngoplasty (UPPP) is an accepted means of surgical treatment for palate (retropalatal) obstruction, resulting in substantially fewer episodes of apnea, a reduction in mortality hazard and, in some patients, apparent cure. UPPP by itself is less successful in patients with multiple sites of obstruction, and in a portion of these patients there may therefore be a demonstrable need for multi-site surgery.

Various other anatomic abnormalities (such as, but not limited to, enlarged tonsils, enlarged tongue, intraoral abnormalities, or nasal obstruction) sometimes cause or exacerbate OSA. Surgical approaches to these abnormalities will vary according to the anatomic defect demonstrated to be causing the obstruction and the procedure(s) needed to correct the defined problem. For example, reduction of obstructing hypertrophied turbinates has been shown to significantly improve nasal airflow and improve both CPAP usage and OSA symptoms.

For those patients where it is documented in the chart that the above approaches are inadequate or inappropriate, and when documented that retrolingual obstruction is a significant component, genioglossus advancement and/or hyoid suspension may be indicated to reduce the obstruction.

Mandibular maxillary osteotomy and advancement is a procedure developed for those patients with retrolingual obstruction, with or without retropalatal obstruction, who have not responded to CPAP, usually following other site-specific surgical treatments noted above.

Tracheostomy remains the most effective of all surgical and nonsurgical treatments for OSA since it bypasses all areas of obstruction in the nasal, palatal, lingual and pharyngeal areas. However, tracheostomy is associated with significant morbidity, and is usually reserved for patients who have failed other medical or surgical methods of treatment, or who are unsuited for other methods of treatment for various reasons.

Oral Appliances for OSA

The Durable Medical Equipment Medicare Administrative Contractors (DMAC) considers oral appliances for OSA to be Durable Medical Equipment and lists the following items of information that must accompany a claim:

1. The name of the manufacturer of the specific device provided.
2. A statement of the estimated appliance useful lifetime before replacement is necessary.
3. Documentation from the treating physician stating the diagnosis, what other therapy had been tried or considered and why the oral appliance is being ordered.

4. A copy of the polysomnogram (or home sleep study) report which documents the patient's sleep disorder and a copy of a sleep study report which documents improvement with the use of the oral appliance.

The device must be billed to the appropriate DMAC using E0485 or E0486.

Continuous Positive Airway Pressure (CPAP) Therapy For Obstructive Sleep

A. General

Continuous positive airway pressure (CPAP) is a non-invasive technique for providing single levels of air pressure from a flow generator, via a nose mask, through the nares. The purpose is to prevent the collapse of the oropharyngeal walls and the obstruction of airflow during sleep, which occurs in obstructive sleep apnea (OSA).

B. Nationally Covered Indications

The use of CPAP is covered under Medicare when used in adult patients with moderate or severe OSA. The use of CPAP devices must be ordered and prescribed by the licensed treating physician to be used in adult patients OSA if either of the following criterion using the Apnea-Hypopnea Index (AHI) are met:

- AHI or RDI greater than or equal to 15 events per hour, or
- AHI or RDI greater than or equal to 5 and less than or equal to 14 events per hour with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders or insomnia, or documented hypertension, ischemic heart disease, or history of stroke.

The AHI is equal to the average number of episodes of apnea and hypopnea per hour. The Respiratory Disturbance Index (RDI) is equal to the average respiratory disturbances per hour. Both should be based on a minimum of 2 hours of sleep recorded, if the AHI or RDI is calculated on less than two hours of continuously recorded sleep, the total number of recorded events to calculate the AHI or RDA during sleep testing must be at a minimum the number of events that would have been required in a two hour period.

These tests are recorded by polysomnography or by sleep testing devices that are unattended in or out of a sleep lab facility or attended in a sleep lab facility using a FDA approved Type II, III, or IV portable device recording at least 3 channels using actual recorded hours of sleep.

Apnea is defined as a cessation of airflow for at least 10 seconds. Hypopnea is defined as an abnormal respiratory event lasting at least 10 seconds with at least a 30 percent reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a 4 percent oxygen desaturation.

Polysomnography must be performed in a facility - based sleep study laboratory, and not in the home or in a mobile facility.

Performance of home sleep testing is limited to FDA cleared devices furnished with adequate patient instruction and support to assure successful completion of the studies. Provision of the device, patient instruction and support can be provided by accredited sleep centers as well as Independent Diagnostic Testing Facilities and other entities that can demonstrate use of FDA approved devices, inspection of the devices, and the patient support activities required. The provider may be subject to post payment audit to document these activities.

Physician services related to home sleep testing are covered for the purpose of determining a diagnosis of OSA if:

- It is reasonable and necessary for the diagnosis of the patient's condition
- It is performed for patients with a high pretest probability of moderate to severe OSA
- It is performed in conjunction with a comprehensive sleep evaluation
- It meets all other Medicare requirements

The DMAC (Durable Medical Equipment Administrative Contractors) are responsible for providing CPAP devices. They are publishing a policy that requires the following standards of credentialing for individuals who interpret sleep testing results that are required for coverage of CPAP:

"Home sleep testing must be interpreted by a physician who holds either:

1. Current certification in Sleep Medicine by the American Board of Sleep Medicine (ABSM); or
2. Current subspecialty certification in Sleep Medicine by a member board of the American Board of Medical Specialties (ABMS); or
3. Completed residency or fellowship training by a program approved by an ABMS member board and has completed all the requirements for subspecialty certification in sleep medicine except the examination itself and only until the time of reporting of the first examination for which the physician is eligible; or
4. Active staff membership of a sleep center or laboratory accredited by the American Academy of Sleep Medicine or the Joint Commission."

Initial claims must be supported by medical documentation (separate documentation where electronic billing is used), such as a prescription written by the patient's attending physician that specifies:

- A diagnosis of moderate or severe obstructive sleep apnea.

The claim must also certify that the documentation supporting a diagnosis of OSA (described above) is available.

A supplier with a significant financial interest in such facilities would not be considered a qualified provider or supplier of these tests for purposes of Medicare coverage for CPAP devices. This prohibition does not apply to studies conducted by hospitals certified to do such tests.

UPPP is covered **only** for those patients who have **all** of the following:

1. Obstructive sleep apnea diagnosed (prior to any proposed surgery);
2. An apnea-hypopnea index as noted above;
3. Failure to respond to CPAP therapy or demonstrated inability to tolerate CPAP or other appropriate non-invasive treatment;
4. Counseling by a physician with recognized experience in sleep disorders, about the potential benefits and risks of the surgery; and
5. Evidence of retropalatal or combination retropalatal/retrolingual obstruction as the cause of the obstructive sleep apnea. The medical record must document the specific nature and extent of the obstruction, such as elongated soft palate, redundant lateral pharyngeal wall and/or excess tonsillar tissue.

Genioglossus advancement and/or hyoid suspension, and/or mandibular maxillary osteotomy and advancement are covered **only** for patients who have **all** of the following:

1. Obstructive sleep apnea diagnosed (prior to any proposed surgery);
2. An apnea-hypopnea index as noted above;
3. Failure to respond to Continuous Positive Airway Pressure therapy or demonstrated inability to tolerate CPAP and other appropriate non-invasive treatment;

4. Evidence of retrolingual obstruction (alone or as a significant contributor in combination with other site(s) of obstruction) as the cause of the obstructive sleep apnea, or previous failure of UPPP to correct the obstructive sleep apnea with evidence that retrolingual obstruction remains a significant, and potentially correctable cause, and
5. Counseling by a physician, with recognized experience in both sleep disorders, and potential, alternative surgical approaches, about the potential risks and benefits of the surgery.

Regarding mandibular maxillary osteotomy and advancement:

1. Separate repositioning of teeth would not be necessary except under unusual circumstances, but if necessary, the dental work would be covered.
2. Application of an interdental fixation device is occasionally necessary and is then a covered service (see documentation requirements).

Tracheostomy is covered for OSA that is unresponsive to other means of treatment or in cases where other means of treatment would be ineffective or not indicated.

When OSA is caused by discrete anatomic abnormalities of the upper airway (such as, but not limited to, enlarged tonsils, enlarged tongue, intraoral abnormalities, or nasal obstruction), surgery to correct these abnormalities is covered if medically necessary based on adequate documentation in the medical records supporting the significant contribution of these abnormalities to OSA. Submucous radiofrequency reduction of hypertrophied turbinates is covered as an appropriate treatment for nasal obstruction due to turbinate hypertrophy that significantly contributes to OSA or significantly compromises CPAP therapy. Submucous radiofrequency reduction of hypertrophied turbinates should be billed with CPT code 30140-52.

Radiofrequency tongue base reduction is covered in treating obstructive sleep apnea only in selected patients meeting the above criteria who do not or can not achieve or sustain adequate improvement from CPAP, when performed in sites and by providers experienced in the procedure, and where all of the following are met and documented in the record:

1. Obstructive sleep apnea diagnosed (prior to any proposed surgery);
2. An apnea-hypopnea index as noted above;
3. Failure to respond to Continuous Positive Airway Pressure therapy or demonstrated inability to tolerate CPAP and other appropriate non-invasive treatment;
4. Evidence of lingual obstruction specifically documented to be due to tongue hypertrophy as the cause of the obstructive sleep apnea (alone or as a significant contributor in combination with other site(s) of obstruction), and
5. Counseling by a physician, with recognized experience in both sleep disorders, and potential, alternative surgical approaches, about the potential risks and benefits of the surgery.

Radiofrequency tongue base reduction is billed using 41530 Submucosal ablation of the tongue base, one or more sites, per session.

Laser-assisted uvulopalatoplasty (LAUP) is not covered at this time since it is not considered effective for OSA. LAUP **must not** be billed as 42145, Palatopharyngoplasty (e.g., uvulopalatopharyngoplasty, uvulopharyngoplasty). This code is not appropriate for this procedure. If LAUP is billed for denial purposes, it should be coded as 42299, (unlisted procedure, palate, uvula) with "LAUP" listed in Item 19 on the CMS-1500 claim form or equivalent field for electronic claims. The claim will then be appropriately denied as not proven effective.

Somnoplasty™ is a trade name for palate reduction with the Somnoplasty™ System of Somnus Medical Systems. This is not a term recognized by this A/B MAC as a covered procedure under Medicare Part B. Therefore Somnoplasty™ must not be billed as 42145. This code is not appropriate for this procedure. If Somnoplasty™ is billed for denial purposes, it should be coded as 42299, (unlisted procedure, palate, uvula) with "Somnoplasty™" listed in Item 19 on the CMS-1500 claim form or equivalent field for electronic claims. This claim will then be appropriately denied as not proven effective.

The Pillar Procedure™ is a trade name for palatal implants. Palatal implants have not been shown effective for the treatment of obstructive sleep apnea and are not covered. This procedure should be billed as 42299 (unlisted procedure, palate, uvula) with "Pillar Procedure™" or "palatal implant" listed in Item 19 on the CMS-1500 claim form or equivalent field for electronic claims. This claim will then be appropriately denied as not proven effective.

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Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

999x	Not Applicable
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Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

99999	Not Applicable
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CPT/HCPCS Codes

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21110	APPLICATION OF INTERDENTAL FIXATION DEVICE FOR CONDITIONS OTHER THAN FRACTURE OR DISLOCATION, INCLUDES REMOVAL
21141	RECONSTRUCTION MIDFACE, LEFORT I; SINGLE PIECE, SEGMENT MOVEMENT IN ANY DIRECTION (EG, FOR LONG FACE SYNDROME), WITHOUT BONE GRAFT
21145	RECONSTRUCTION MIDFACE, LEFORT I; SINGLE PIECE, SEGMENT MOVEMENT IN ANY DIRECTION, REQUIRING BONE GRAFTS (INCLUDES OBTAINING AUTOGRAFTS)
21196	RECONSTRUCTION OF MANDIBULAR RAMI AND/OR BODY, SAGITTAL SPLIT; WITH INTERNAL RIGID FIXATION
21199	OSTEOTOMY, MANDIBLE, SEGMENTAL; WITH GENIOGLOSSUS ADVANCEMENT
21685	HYOID MYOTOMY AND SUSPENSION
30140	SUBMUCOUS RESECTION INFERIOR TURBINATE, PARTIAL OR COMPLETE, ANY METHOD
30802	ABLATION, SOFT TISSUE OF INFERIOR TURBINATES, UNILATERAL OR BILATERAL, ANY METHOD (EG, ELECTROCAUTERY, RADIOFREQUENCY ABLATION, OR TISSUE VOLUME REDUCTION); INTRAMURAL (IE, SUBMUCOSAL)
31600	TRACHEOSTOMY, PLANNED (SEPARATE PROCEDURE);
31610	TRACHEOSTOMY, FENESTRATION PROCEDURE WITH SKIN FLAPS
41512	TONGUE BASE SUSPENSION, PERMANENT SUTURE TECHNIQUE
41530	SUBMUCOSAL ABLATION OF THE TONGUE BASE, RADIOFREQUENCY, 1 OR MORE SITES, PER SESSION
42145	

PALATOPHARYNGOPLASTY (EG, UVULOPALATOPHARYNGOPLASTY, UVULOPHARYNGOPLASTY)

ICD-9 Codes that Support Medical Necessity

These are the **only** covered diagnoses for CPT codes **21685, and 42145**. This list will not address the other listed HCPCS services/procedures.

327.23	OBSTRUCTIVE SLEEP APNEA (ADULT) (PEDIATRIC)
780.51	INSOMNIA WITH SLEEP APNEA, UNSPECIFIED
780.53	HYPERSOMNIA WITH SLEEP APNEA, UNSPECIFIED
780.57	UNSPECIFIED SLEEP APNEA

These are the **only** covered diagnoses for CPT code **41512, 41530**:

***Both** the primary ICD-9-CM code 327.23 (Obstructive sleep apnea) and at least one of the following secondary codes (529.8 or 750.15) must be present on the claim.

Primary diagnosis code for CPT codes 41512, 41530:

327.23	OBSTRUCTIVE SLEEP APNEA (ADULT) (PEDIATRIC)
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Secondary diagnosis code for CPT codes 41512, 41530:

529.8*	OTHER SPECIFIED CONDITIONS OF THE TONGUE
750.15*	MACROGLOSSIA

Note that ICD-9-CM code 529.8 may be used only for tongue hypertrophy. Each of the conditions must be documented in the medical record which must be made available to Medicare on request.

Diagnoses that Support Medical Necessity

All ICD-9-CM codes listed in this policy under "ICD-9-CM Codes That Support Medical Necessity" above.

ICD-9 Codes that DO NOT Support Medical Necessity

All ICD-9-CM codes **not** listed in this policy under "ICD-9-CM Codes That Support Medical Necessity" above.

ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation

Diagnoses that DO NOT Support Medical Necessity

All ICD-9-CM codes **not** listed in this policy under "ICD-9-CM Codes That Support Medical Necessity" above.

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General Information

Documentations Requirements

Claims for co-surgery will require an accompanying written report of the procedure and justifications for co-surgery and must be made available to Medicare upon request.

Laser-assisted uvulopalatoplasty (LAUP) is not covered at this time since it is not considered effective for OSA. LAUP must not be billed as 42145. (See information above under "Indications and Limitations of Coverage and/or Medical Necessity.")

Somnoplasty™ is a trade name for palate reduction with the Somnoplasty™ System of Somnus Medical Systems. This is not a term recognized by this A/B MAC as a covered procedure under Medicare Part B. Therefore Somnoplasty™ must not be billed as 42145. (See information above under "Indications and Limitations of Coverage and/or Medical Necessity.")

The Pillar Procedure™ is a trade name for palatal implants. Palatal implants are not a term recognized by this A/B MAC as a covered procedure under Medicare Part B. Therefore the Pillar Procedure™ or palatal implants must not be billed as 42145. (See information above under "Indications and Limitations of Coverage and/or Medical Necessity.")

Documentation supporting the medical necessity for any dental work done with the procedure must be made available to Medicare upon request.

Documentation supporting the medical necessity for the procedure, including all documentation listed under the "Indications and Limitations of Coverage" section, must be made available to Medicare upon request.

Documentation of the counseling of the risks and benefits of the procedure must be available, if necessary, for review.

Documentation that CPAP or other modes of continuous positive airway pressure therapy for OSA has had adequate trial under the care of a physician especially trained in sleep disordered breathing must be available, if necessary, for review. Absence of this information could result in denial of payment.

Any claim which includes application of an interdental fixation device will require submission of a written report attesting to the medical necessity of the device and made available to Medicare upon request.

The HCPCS/CPT code(s) may be subject to Correct Coding Initiative (CCI) edits. This policy does not take precedence over CCI edits. Please refer to the CCI for correct coding guidelines and specific applicable code combinations prior to billing Medicare.

When the documentation does not meet the criteria for the service rendered or the documentation does not establish the medical necessity for the services, such services will be denied as not reasonable and necessary.

When requesting a written redetermination (formerly appeal), providers must include all relevant documentation with the request.

Appendices

Utilization Guidelines

Sources of Information and Basis for Decision

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Contractor Advisory Committee meeting dates:

California - 11/19/2008

Hawaii - 10/31/2008

Nevada - 11/06/2008

Start Date of Comment Period 10/30/2008

End Date of Comment Period 12/15/2008

Start Date of Notice Period 02/05/2009

Revision History Number Revision #8,

Revision History Explanation Revision #8 effective for dates of service on or after 01/27/2011

Revisions made: Under CMS National Coverage Policy removed the statement (CR 6534 Transmittal 103, Dated July 10, 2009) following Pub. 100-03, Medicare National Coverage Determinations, Chapter 1, Part 4, §240.4.1, as this CR has been manualized. Under Sources of Information and Basis for Decision added an authors name to article titled "The Efficacy of Surgical Modifications of the Upper Airway in Adults with Obstructive Sleep Apnea Syndrome." Authors names were added to the article titled Practice Parameters for the Treatment of Obstructive Sleep Apnea in Adults: the Efficacy of Surgical Modifications of the Upper Airway." Added authors names to the book titled "Harrison's Principles of Internal Medicine." The article titled Genioglossus muscle advancement with the genioglossus bone advancement technique for base of tongue obstruction) was corrected to "Early experience evaluating the efficacy of genioglossus advancement utilizing the genioglossus bone advancement technique for symptomatic base of tongue obstruction." Removed the reference "Other carriers' medical policies" as this did not mention the specific names of the carriers or the name(s) of the medical policies used to base the decision for this LCD. Added publication month, and/or issue to various references cited in this LCD. Two additional references were added to this section of the LCD which are more recent publications and supported the LCD position.

Revision #7, effective for dates of service on or after 08/10/2009

Revisions made: Under section titled "CMS National Coverage Policy", Pub. 100-03, Chapter 1 Part 4, §240.4 the section was changed to 240.4.1, with the appropriate CR 6534 for this change. Under Indications and Limitations of Coverage and/or Medical Necessity, subtitle Continuous Positive Airway Pressure (CPAP) Device the paragraph referring sleep testing devices Type II, III or IV now states that these tests are covered if performed unattended in or out of a sleep lab facility or attended in a sleep lab facility.

Revision #6, effective for dates of service on or after 03/23/2009

The following LCDs are being revised to implement the streamlining of the Part B LCDs per the published article "Palmetto Team to Streamline Part B LCDs in Jurisdiction 1 (J1)." This article can be viewed at www.PalmettoGBA.com by searching for the above article name. These revisions will become effective on 03/23/2009.

Revision 5, 03/23/2009

Under "CMS National Coverage Policy" added Pub. 100-03, *Medicare National Coverage Determinations*, §240.4, which manualized Medicare National Coverage Determination/Decision Memo CAG-00093R2, resulting in the removal of this reference. "Indications and Limitations of Coverage and/or Medical Necessity" formatting changes were made to ensure the clarity of the LCD. Clarification of the language of AHI and RDI was made to this section of the LCD. Under "Documentation Requirements" removed the requirement that documentation must be submitted with the claim and replaced this statement with "must be made available to Medicare upon request."

Revision #4, Draft

Revision Made: "CMS National Coverage Policy" duplicated wording was removed; completed manual citations; Annual 2009 CPT/HCPCS Update; added CPT codes 41512 and 41530 as other covered treatments of OSA. Deleted 0088T from the CPT/HCPCS array. Under "ICD-9 Codes that Support Medical Necessity" added 42512 and 41530 and deleted 0088T in Groups 2 and 3. "Sources of Information and Basis for Decision" references placed in AMA citation format. These LCD code revisions will become effective 01/01/2009. Indications and Limitations of Coverage and or Medical Necessity" is still out for comment at the time of this update.

Revision #3, DRAFT

Revisions made: Corrected "CMS National Coverage Policy" formatting and removed duplicate verbiage. In the "Indications and Limitations of Coverage and/or Medical Necessity" section added credentialing requirement for a individuals who interprets sleep testing results that are required for coverage of CPAP from DMAC and clarified NCD for Home Sleep Testing. Under "Documentation Requirements" removed duplicate citation referenced in the "CMS National Coverage Policy." "Sources of Information and Basis for Decision" references were put in AMA citation format.

Revision #2, 09/02/2008

Under Indications and Limitations of Coverage and/or Medical Necessity-Oral Appliances for OSA revised the cited DMAC oral device codes to now read, "E0485 and E0486." Under CPT/HCPCS Codes deleted E0601 and E1399. This LCD was reviewed and revised to address full implementation of the Coverage Decision Memo CAG-0093R2. This revision becomes effective 09/02/2008.

Revision #1, 09/02/2008

This LCD is being revised to add Bill Type 999X because the automated system transcription process was incomplete.

11/15/2009 - The description for CPT/HCPCS code 30802 was changed in group 1

11/15/2009 - The description for CPT/HCPCS code 41530 was changed in group 1

11/21/2010 - For the following CPT/HCPCS codes either the short description and/or the long description was changed. Depending on which description is used in this LCD, there may not be any change in how the code displays in the document:

21141 descriptor was changed in Group 1

21145 descriptor was changed in Group 1

42145 descriptor was changed in Group 1

Reason for Change

Last Reviewed On Date 01/20/2011

Related Documents

This LCD has no Related Documents.

LCD Attachments

There are no attachments for this LCD.

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All Versions

Updated on 01/21/2011 with effective dates 01/27/2011 - N/A

Updated on 11/21/2010 with effective dates 08/10/2009 - 01/26/2011

Updated on 01/29/2010 with effective dates 08/10/2009 - N/A

Updated on 11/15/2009 with effective dates 08/10/2009 - N/A

Updated on 07/14/2009 with effective dates 08/10/2009 - N/A

Updated on 02/19/2009 with effective dates 03/23/2009 - 08/09/2009

Updated on 01/28/2009 with effective dates 03/23/2009 - N/A

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